STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675831	A. Building B. Wing	04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regent Care Center of El Paso	10880 Edgemere Blvd El Paso, TX 79935

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on observation, interview and record review the facility failed to ensure residents has a right to a dignified existence for 1 resident (Resident #2) out of 14 reviewed for rights to a dignified existence in that: Therapy Staff G told Resident #2 she should be working and not talking, and that tape would be put on her mouth if she continued to talk, leaving Resident #2 feeling embarrassed, and reluctant to talk to anyone while involved in therapy. This failure could result in residents feeling embarrassed, reluctant to talk and reluctant to engage in therapy, affecting their progress in achieving their goals for rehabilitation. Finding include: Closed record review of Resident #2's face sheet dated 03/27/2024 revealed that she was [AGE] years old, was admitted to the facility on [DATE] and discharged home on 03/16/2024. Closed record review of Resident #2's history and physical dated 02/22/2024 revealed she had a total left knee replacement on 02/15/2024 and had her gallbladder removed on 02/17/2024. Treatment plans included evaluation by physical and occupational therapy. Closed record review of Resident #2's admission MDS dated [DATE] revealed she had a BIMS score of 13 (cognitively intact). She had no symptoms of delirium, depression or psychosis and had no behavioral symptoms. She required She required substantial assistance for lower body dressing and putting on/taking off foot wear. She required moderate assistance for toileting and bathing. She recently had knee replacement surgery. She had received 318 minutes of occupational therapy starting on 02/22/2024 and 311 minutes of physical therapy starting on 02/22/2024. Closed record review of Resident #2's care plan dated 02/24/2024 revealed she was at risk for falls. Interventions included to be referred to physical therapy for evaluation. Care plan dated 02/24/2024 stated she required staff assistance with bathing. The physical therapist was to work with her on transfers and ambulation, and the occupational therapist was to work with her on ADL re-training. Care Plan dated 02/24/2024 stated she required assistance for some ADL's. Nursing and nursing assistants were to encourage the resident to participate with PT and OT as ordered. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Regent Care Center of El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE 10880 Edgemere Blvd El Paso, TX 79935	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Closed record review of Resident #2's physician's orders dated 02/22/2024 revealed she was to be evaluated by physical therapy and occupational therapy and treated as needed. Closed record review of Resident #2's Resident Incident Report dated 03/14/2024 revealed that on 03/14/2024 Resident #2's family member reported to the social worker that during the first week of therapy a male therapist (discipline not identified) had placed a piece of tape over the resident's mouth while doing therapy. The family member reported that Resident #2 was talking with two male residents (Resident #12 and an unidentified resident.) Resident #2 was examined with no new injuries/bruises or skin issues identified. Record review of social services interview summaries dated 03/14/2024 revealed that during an interview with Resident #2, the resident said that during her first week of therapy she was on the exercise bike talking with two male residents [Resident 12 and an unidentified resident] , when a therapist approached her and placed yellow paper tape over her mouth. Record review of a written statement dated 03/14/2024 by Therapy Staff G revealed he that at some point between 02/25/2024 and 03/01/2024 he playfully told Resident #2 .we need more work and less talking . after which Therapy Staff G jokingly said .we use tape . The written statement said Resident #2 laughed and continued exercising. Record review of Therapy Staff G's employee record revealed that the criminal history check and EMR/NAR checks had been conducted as required and that no concerns were identified. Record review of grievances revealed no grievances had been raised regarding Therapy Staff G besides the one that was brought to the attention of the facility on 03/14/2024. The grievance documentation . In an interview on 04/01/ 2024 at 8:28 AM, the family member of Resident #2 said she was not able to pinpoint when the incident occurred. She said Resident #2 reported that she was in the therapy room and greeted two male residents. She said hello to one and the other resident asked why she did not say hello to him. She started to explain when Therapy Staff G said, Here we don't talk, and put tape on her mouth. The resident reported to her family member that it made her very embarrassed. The resident told her family member she did not remember who removed the tape from her mouth because she was focused on remembering not to speak, and that she thought about the incident all day. The resident said the tape placed on her mouth was white. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Regent Care Center of El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE 10880 Edgemere Blvd El Paso, TX 79935	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In observation, record review and interview on 04/01/2024 at 9:09 AM with the Rehabilitation Director, the therapy room was inspected for tape of any kind. No tape was observed except for scotch tape. Record review revealed that Resident #2 received occupational therapy services from Therapy Staff G daily from 2/26 - 2/29/24, 3/1 - 3/4/24, 3/8/24 and 3/11 - 3/14 2024. The the Rehabilitation Director said she had not heard of any concerns regarding Therapy Staff G except the alleged incident with Resident #2. The Rehab Director said she had been advised of the allegation by the facility Administrator who investigated the allegation. She stated that since therapy services were provided through contract with the facility, information about the allegation had also been passed along her supervisor. The Rehabilitation Director stated that Therapy Staff G was suspended for one day during the investigation of the allegation, and that she spoke to Therapy Staff G and took his statement regarding the incident. The Rehabilitation Director counseled Therapy Staff G about professionalism. The Rehabilitation Director discussed the allegations with other employees, but no one said they had heard or seen this event. There was no camera in the therapy room. In an interview on 04/01/2024 at 9:30 AM Therapy Staff H said she had never heard or said that a resident's mouth would be taped. She said that the last time there had been tape in the therapy room was over a year ago. She said it was kinesiology tape, and it was never white. In an interview on 04/01/2024 at 9:33 AM Therapy Staff I said he had never heard or said that they would tape a resident's mouth for any reason. In an interview on 04/01/2024 at 10:15 AM, Therapy Staff G revealed that he remembered working with Resident #2. He said that Resident #2 was initially very quiet, but that during the last few weeks before her discharge, she became more talkative. Therapy Staff G said he was joking with Resident #2 during the 2-3 weeks before her discharge. He revealed he told Resident #2 Menos platicar y mas tarbajar, si no se [NAME] tape asi [Less talking and more work, if not we put a tape like this] - and that he gestured to the resident putting tape over his mouth. Therapy Staff G said both he and Resident #2 laughed and that was it. Therapy Staff G stated he did not use tape in his work, and that there was no tape in the vicinity of the residents in the therapy room. Therapy Staff G's time log was reviewed with him, but he was unable to pinpoint the time frame during which the incident took place. He denied putting tape on Resident #2's mouth and denied showing her a piece of tape. He stated that if he put tape on her mouth would most likely be considered abuse. In a follow-up interview on 04/01/2024 at 10:34 AM, Resident #2's family member said that if the type of tape used was scotch tape, the resident would have mentioned it. In a telephone interview on 04/01/2024 at 10:48 AM, Resident #2 revealed she received therapy for her arms. She said she did not remember the therapists but that they treated her well. Resident #2 said the therapists did not joke around with her. She said Therapy Staff G put tape on her mouth that was like packing tape, not scotch tape. She said she did not see anyone else with tape on their mouths. She said there were other residents and workers in the room at the time of the incident but did not remember who they were. She stated that the incident embarrassed her, and she did not talk to anyone in therapy anymore except to say hello and good morning. Resident #2 was not able to recall remember when the incident occurred but thought it was in the middle of her stay at the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regent Care Center of El Paso	10880 Edgemere Blvd El Paso, TX 79935

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/01/2024 at 11:13 AM, Resident #12 revealed he was receiving therapy for his arms and legs. He said he sometimes chatted with the residents. He said he had not been told not to talk to other residents. Resident #12 said he had not heard a therapist tell another resident they should not be talking and had not seen therapists using tape. He said he had not seen therapists put tape on someone's mouth. In an interview on 04/01/2024 at 11:52 AM, Resident #15 revealed she was getting physical therapy and that the workers treated her with dignity and respect. In an interview on 04/01/2024 at 11:55 AM, Resident #16 said he had been in the facility since December and was getting all forms of therapy. He said the therapists treated him well. He had not seen them use tape in therapy and had not been told he could not talk. He said he had not seen therapists use tape on resident's mouths. In an interview on 04/01/2024 at 12:00 PM Resident #17 said she received occupation and physical therapy. She said she had worked with Therapy Staff G and he was nice. She said that all the therapy staff joked around. She said no tape had been used with her or other residents, and that she had not been told not to talk. In an interview on 04/01/2024 at 12:05 PM the family member of Resident #18 said she had been with the resident to therapy a few times. The family member said the therapy staff treated the resident with dignity and respect. She had not seen the therapists use tape with anyone and had not heard them tell anyone not to talk. She did the therapist who provided services to the resident was a woman. Record review of the facility policy Resident Rights (undated) revealed employees shall treat all residents with kindness, respect and dignity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Regent Care Center of El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE 10880 Edgemere Blvd El Paso, TX 79935	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on observation, interview and record review the facility failed to ensure residents in the facility were free from neglect for 1 (Resident #1) of 14 residents reviewed for neglect in that: Resident #1 was found unresponsive on [DATE] around 7:25 AM by CNA C who immediately notified RN A. RN A who was responsible for Resident #1 did not know the process and procedures that were to be followed when a full-code resident was found unresponsive, resulting in the resident not being provided CPR. An IJ was identified on [DATE] at 10:25 AM. The IJ template was provided to the facility on [DATE] at 10:25 AM. While the IJ was removed on [DATE] at 6:55 PM the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm, because all staff had not been trained on Emergency Response Procedure and Calling a Code. These failures could place residents at risk for serious injury, hospitalization and/or death. Findings included: Record review of Resident #1's face sheet dated [DATE] revealed he was [AGE] years old, was admitted to the facility on [DATE] and discharged on [DATE] due to death in the facility. The face sheet did not indicate his code status. Record review of Resident #1's history and physical dated [DATE] revealed he had diagnoses including coronary artery disease (damage or disease of the hearts major blood vessels), osteomyelitis (infection in the bone), Diabetes mellitus with hyperglycemia (Diabetes with high blood sugar), hypertension (high blood pressure, vascular dementia (dementia caused by blood clots in the brain) and hemiparesis affecting left side as late effect of cerebrovascular accident (Stroke affecting his left side). Record review of Resident #1's admission MDS dated [DATE] revealed he had a BIMS score of 8 (moderate cognitive impairment). He had symptoms of delirium including fluctuating periods of inattention and disorganized thinking. He had symptoms of psychosis including hallucinations (seeing something that is not actually there). He had no symptomatic behaviors. He was dependent on staff for toileting, bathing, dressing, personal hygiene, sitting up, and transferring between surfaces. Record review of Resident #1's care plan dated [DATE] revealed he was a full code status, that the facility would honor his wishes regarding code status and attempt to resuscitate him should arrest occur. His physician would be contacted, emergency services would be notified, and family would be notified. Record review of Resident #1's physician's orders dated [DATE] revealed no orders concerning his code status. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Regent Care Center of El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE 10880 Edgemere Blvd El Paso, TX 79935	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Advance Directives information in his electronic record accessed [DATE] revealed his CPR (Resuscitation) Status was Attempt CPR. Record review of Resident #1's progress note dated [DATE] at 10:53 AM by RN A documented the following Resident found unresponsive by this nurse, initially attempted vitals but was unsuccessful, CPR initiated immediately, code cart brought to room, AED in place with commands initiated, 911 called, CPR continued till EMS arrived and took over. DON, Administrator, and MD notified. Family called and updated. All questions and concerns addressed. Record review of the fire department's Hospital Care Report for Resident #1 dated [DATE] beginning at 7:55:12 AM revealed that paramedics were dispatched to the facility at 7:56 AM and arrived at the resident's bedside at 8:07 AM. The resident was pale and cold, pulseless and apneic (not breathing) and facility staff were performing compressions. Facility staff reported to the paramedics they noticed the resident was not breathing at around 7:20 AM and had called 911 around 7:55 AM. The paramedics took over compressions, established IV (needle in a vein) access, placed oxygen on the resident and administered epinephrine (adrenaline) and normal saline. The patient (Resident #1) was found in asystole (without a heartbeat) and remained in the same cardiac rhythm. The paramedics contacted physician (unidentified) who gave permission to discontinue ALS (Advance Life Support) interventions. CPR was discontinued on [DATE] at 8:17 AM. The paramedics advised the nurse at the facility of the doctor's orders, and the paramedics left. The resident was not transported from the facility. Record review of the facility's self-report Intake Investigation Worksheet dated [DATE] revealed an allegation of neglect because RN A found Resident #1 unresponsive on [DATE] at 7:38 AM but did not initiate CPR until 16 minutes later at 7:55 AM. In an interview on [DATE] at 8:31 AM, the ADON revealed she received a telephone call at 7:40 AM on [DATE] from the DON that RN A had texted the DON at 7:38 AM that Resident #1 had expired. The DON asked the ADON to go to the facility to initiate CPR and call 911. The ADON stated she arrived at the facility at 7:54 AM and found RN A at the nurse's station at the front of the building. Per the ADON she asked RN A who was with Resident #1 and RN A said No one. The ADON stated she then ran to Resident #1's room with RN A and when she arrived the crash cart was in the resident's room but there were no staff members there. The ADON said she called 911 at 7:55 AM while RN A initiated CPR assisted by LVN D, and CNAs C and E who had arrived at the room by then. Per the ADON, CNA C had gone into Resident #1's room to get him up for breakfast, found him unresponsive, and notified RN A. The ADON stated she asked RN A why CPR was not initiated, and RN A said that he was already cold and grey, and that she (RN A) did not know what to do, that this type of situation was handled differently in the hospital where she had worked before. [RN A date of hire [DATE]]. The ADON stated that RN A had not alerted other nurses in the facility about Resident #1's condition. She said that an investigation was done, with RN A being suspended and later terminated in response to the investigation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regent Care Center of El Paso	10880 Edgemere Blvd El Paso, TX 79935

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

In an interview on [DATE] at 12:39 PM, the DON revealed that when CNA C told RN A that Resident #1 was unresponsive and the RN found the resident unresponsive, the RN should have started the code. She said the Code Blue procedure involved the nurse getting help from other staff in announcing Code Blue on the intercom, taking the crash cart and AED to the resident's room, and calling 911 while responding nurses and other responding staff would place a back board under the resident, start chest compressions, place and use the ambu-bag (bag used to help a patient's breathing), place the AED pads on the patient's chest and follow instructions from the AED machine. The DON said that that these compressions, use of the ambu-bag and following instructions from the AED should continue until paramedics arrived to take over the situation. She said that RN A was suspended pending investigation of the incident, and later was terminated.

In an interview on [DATE] at 4:59 PM the DON revealed that the facility had not done any training about how to respond to this type of emergency [an unresponsive patient who is full-code], because nothing like this had happened before. She stated that nurses learned about CPR in outside classes when they got their CPR cards renewed.

Telephone attempts to reach RN A were made on [DATE] at 9:34 AM, and on [DATE] at 8:15 AM, 9:21 AM, and 11:24 AM with no response although requests for a return call were left in her digital mailbox.

Record review of RN A's personnel file revealed she was hired on [DATE]. She initialed a New Hire Orientation Acknowledgement that included location and information about the AED on [DATE].

In an interview on [DATE] at 8:31 AM, LVN D said she became aware of the incident involving Resident #1 before breakfast on [DATE] when RN A came to her asking what the procedure was when a resident was found with no vital signs. LVN D said RN A was not sure if Resident #1 had a DNR order or had a full code status. LVN D said she went to the nurse's station and found a green sheet of paper in his file [denotes full code status] and then looked in his electronic chart which also showed he had a full code status. LVN D said when she discovered Resident #1 had a full-code status she ran to get the crash cart and AED, took them to Resident #1's room. LVN D stated when she arrived at Resident #1's room the room was empty. LVN D said she and RN A arrived at the resident's room together and put the board under his back, opened the AED and placed patches on the resident, started CPR. LVN D said the AED did not shock him. At some point the ADON arrived and was using the ambu-bag. LVN D was not able to state when the ADON arrived.

In an interview on [DATE] at 8:56 CNA E revealed that the morning of [DATE] around 7:25 AM, she was walking down the 400 hall when CNA C came out of Resident #1's room and said he was not moving. CNA E said she looked at Resident #1 who looked grey and was cold to the touch. CNA E said she and CNA C stepped outside the room where RN A had her cart and told the RN that she needed to go into the room because Resident #1 was gone. CNA E said the RN went into Resident #1's room, touched the resident, and pulled the sheet over his head. CNA E said she told the RN Don't do that and the RN pulled the sheet back down. CNA E said the RN then left the room and once outside asked the CNA (CNA E) what the procedure was. CNA E said she did not respond to the RN's question but instead told CNA C what the CNAs did when told by a nurse that a resident had died (wash the body, change the linens, use a towel to close the mouth).

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Regent Care Center of El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE 10880 Edgemere Blvd El Paso, TX 79935	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on [DATE] at 10:52 AM, CNA C revealed she arrived for work on [DATE] around 6:00 AM and began her work. After readying several residents for breakfast, she asked RN A what she needed to for Resident #1. RN A told her to get him up for breakfast, but when CNA C entered Resident #1's room to begin getting him ready, she saw that the resident's face and hands were discolored, and his mouth was wide open. The CNA said she looked at the resident's chest and did not see him breathing. CNA C said she walked out of room and told RN A something was wrong with Resident #1, that he was not breathing and was not ok. CNA C said she went with RN A into Resident #1's room and saw the RN check the resident's pulse and breathing. The CNA followed the RN out of the resident's room where RN A was heard asking CNA E what the procedure was because it was different in different states. CNA C stated she was later going to the dining room to help with breakfast when she saw the ADON, RN A and LVN D go to Resident #1's room with the crash cart. She followed them to the resident's room where she observed the three nurses place the back board, start chest compressions, attach the AED to the resident, and begin use of the ambu-bag. In an interview on [DATE] at 4:22 PM, LVN F revealed that on [DATE] before breakfast (was not able to give specific time) she heard unidentified staff members saying that Resident #1 had expired. LVN F said she was surprised because no one had called a Code Blue. LVN F said she went to Resident #1's room where LVN D, RN A and CNA C were beginning to place the back board under the resident and to start compressions. Record review of the facility's policy Emergency Procedure - Cardiopulmonary Resuscitation dated , d+[DATE] revealed that if an individual is found unresponsive and not breathing normally a licensed staff member who is certified in CPR/BLS (cardiopulmonary resuscitation/Basic life support) shall initiate CPR unless it is know that a DNR order that specifically prohibits CPR and/or external defibrillation exists for the individual. If the resident's DNR status is unclear, CPR will be initiated until it is determined that there is a DNR order or a physician's order to not administer CPR. Record review of the facility's policy Abuse and Neglect - Clinical Protocol dated [DATE] revealed that the definition of neglect was the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The physician and staff will help identify risk factors for abuse within the facility such as those related to staffing such as poor preparation, training, and lack of knowledge or skills that might affect how the residents are being cared for. Staff and management will help identify situations that might constitute or could be construed as neglect such as inattention to advance directives. This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 10:25 AM. The Administrator was notified. The Administrator was provided with the IJ template on [DATE] at 10:25 AM. The Plan of Removal was accepted on [DATE] at 12:12 PM: [DATE] Employee was interview and statement taken. This was completed by [DON name] RN, DON and [ADON name] LVN, ADON on [DATE]. Met with Administrator and decision was made to suspend employee same day on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Regent Care Center of El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE 10880 Edgemere Blvd El Paso, TX 79935	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This was completed by [DON name] RN, DON and [Administrator name], Administrator on [DATE]. Investigation begin by interviewing staff members and taking written statements. This was completed by [DON name] RN, DON on [DATE]. [DATE] Full code and DNR audit were completed to ensure, physician order, code status icon and correct colored paper (green or red) is in chart for all residents. This was completed by [LVN B Name] LVN, Medical records on [DATE]. Continued to take statements from staff members. This was completed by [DON name] RN, DON on [DATE]. Audit CPR certification for nurses completed This was completed by [DON name] RN, DON on [DATE]. CPR certification class was scheduled for Thursday [DATE] at 1:30pm. This was completed by [ADON name] LVN, ADON on [DATE]. In-service on where to find a residents' code status provided to staff. This was completed by [DON name] RN, DON on [DATE]. [DATE] In-services on "Emergency response procedure, calling a code" provided to staff. This was completed by [DON name] RN, DON and [Corporate Staff Name] RN, EDCS on [DATE]. Continue investigation by taking staff statements. This was completed by [DON name] RN, DON and [Corporate Staff Name] RN, EDCS on [DATE]. [DATE] In-services continued on "Emergency response procedure, calling a code" This was completed by [DON name] RN, DON and [Corporate Staff Name] RN, EDCS on [DATE]. Continue investigation by taking staff statements. This was completed by [DON name] RN, DON and [Corporate Staff Name] RN, EDCS on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Regent Care Center of El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE 10880 Edgemere Blvd El Paso, TX 79935	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] Continue investigation by taking staff statements. This was completed by [DON name] RN, DON and [Corporate Staff Name] RN, EDCS on [DATE]. [DATE] In-serviced nurses about what to do when a patient is full code or DNR and found with no signs of life. This was completed by [DON name] RN, DON on [DATE]. Facilities Plan to ensure compliance quickly [DATE] Staff in-service on "Abuse and neglect" and "Emergency response procedure, calling a code: verification of code status, instructing staff to activate emergency response system code, call 911, and initiate basic life support". Staff members will not assume any job responsibilities until training has been received by DON/designee This was completed by [DON name] RN/DON on [DATE]. This will be monitor by DON/designee by conducting 5 random interviews x1 week with staff, record responses and document in regards to knowledge about abuse and neglect and how to reach/do in a code blue situation. DON/designee will report monthly to QAPI [DATE] and ongoing CPR certification class and emergency mock drill training provided on [DATE] at 1:30pm. Will be completed by [Business owner's name] (Owner of [Business name and location]). This will be monitor by DON/designee by conducting 5 random interviews x1 week with staff, record responses and document in regards how to react/do in a code blue situation. DON/designee will report monthly to QAPI Ongoing Emergency mock drills training quarterly. Will be completed by [Business owner's name] (Owner of [Business name and location]). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER: Regent Care Center of El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE: 10880 Edgemere Blvd El Paso, TX 79935	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This will be monitor by DON/designee by conducting 5 random interviews x1 week with staff, record responses and document in regards how to react/do in a code blue situation. DON/designee will report monthly to QAPI Plan of Removal was verified a follows: - Confirmed through interview and record review (DON, [DATE] 4:59 PM; HR Manager [DATE], 9:43 AM) that alleged perpetrator was interviewed, suspended and terminated. - Through interview with 3 LVNs from 6 AM to 6 PM shift and two LVNs from 6 PM to 6 AM shift confirmed understanding of training regarding response to resident without signs of life (LVN F, [DATE] 4:22 PM; LVNs - [DATE] 9:04AM, [DATE] 2:22 PM, 5:08 PM, 5:16 PM.) - Confirmed through interview (Medical Records Director, [DATE] at 3:11 PM) that an audit was performed on all resident records to ensure accuracy of resident code status; confirmed through record review of residents physical and electronic charts ([DATE] at 4:04 PM) the accuracy of resident code status for 12 sample residents (Census of 75). - Confirmed through record review (audit listing with nurse's names and CPR expiration dates) and interview (DON [DATE], 5:05 PM) that nurses' CPR training status was audited, and that the facility has taken action to train one nurse whose CPR training was expired. - Confirmed through observation (Group trainings observed [DATE], at 2:07 PM, 2:50 PM, 3:58 PM), interview (DON [DATE] at 5:05 PM) and documentation (Inservice sign-ins dated [DATE], [DATE], [DATE], [DATE]) that trainings regarding calling a code and regarding determining a resident's code status as identified in the plan of removal were provided. - Confirmed through interview (Administrator [DATE] 3:30 PM) and record review (Service Agreement dated [DATE]) that the facility entered into a service agreement with a provider of BLS and First aid/CPR/AED courses. - Confirmed through interview and record review that ANE training is provided to employees and through interviews with 13 staff (RN (DON [DATE] 5:05 PM; RN [DATE] 2:03 PM), LVN (LVN F, [DATE] 4:22 PM; LVNs [DATE], 5:08 PM, 5:16 PM, CNAs - [DATE] at 10:52, [DATE], 1:52 PM, 1:59 PM, 2:33 PM, 2:57 PM, 3:07 PM, 3:30 PM; 3:40 PM), Restorative Aide ([DATE], 2:11 PM), Activities Director ([DATE], 2:16 PM) understanding of the concept of neglect. - Confirmed through interview that employees (DON [DATE] 5:05 PM) who have not completed Emergency response procedure, calling a code: verification of code status, instructing staff to activate emergency response system code, call 911, and initiate basic life support training will not assume job responsibilities until training has been done. The Administrator was informed the Immediate Jeopardy was removed on [DATE] at 6:55 PM. The facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER: Regent Care Center of El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE: 10880 Edgemere Blvd El Paso, TX 79935	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident’s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on observation, interview and record review the facility failed to ensure personnel provided basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives for 1 (Resident #1) of 14 residents reviewed for physician's orders for provision of basic life support in that: Resident #1 was found unresponsive on [DATE] around 7:25 AM by CNA C who immediately notified RN A. RN A went to the resident's room and checked him for signs of life but did not know how to respond when she did not find a pulse, and did not immediately start CPR or other life-sustaining measures, resulting in Resident #1's wishes to be resuscitated not being honored. An IJ was identified on [DATE] at 10:25 AM. The IJ template was provided to the facility on [DATE] at 10:25 AM. While the IJ was removed on [DATE] at 6:55 PM the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm, because all staff had not been trained on Emergency Response Procedure and Calling a Code. These failures could place residents at risk for serious injury, hospitalization and/or death. Findings included: Record review of Resident #1's face sheet dated [DATE] revealed he was [AGE] years old, was admitted to the facility on [DATE] and discharged on [DATE] due to death in the facility. The face sheet did not indicate his code status. Record review of Resident #1's history and physical dated [DATE] revealed he had diagnoses including coronary artery disease (damage or disease of the hearts major blood vessels), osteomyelitis (infection in the bone), Diabetes mellitus with hyperglycemia (Diabetes with high blood sugar), hypertension (high blood pressure), vascular dementia (dementia caused by blood clots in the brain) and hemiparesis affecting left side as late effect of cerebrovascular accident (Stroke affecting his left side). Record review of Resident #1's admission MDS dated [DATE] revealed he had a BIMS score of 8 (moderate cognitive impairment). He had symptoms of delirium including fluctuating periods of inattention and disorganized thinking. He had symptoms of psychosis including hallucinations (seeing something that is not actually there). He had no symptomatic behaviors. He was dependent on staff for toileting, bathing, dressing, personal hygiene, sitting up, and transferring between surfaces. Record review of Resident #1's care plan dated [DATE] revealed he was a full code status, that the facility would honor his wishes regarding code status and attempt to resuscitate him should arrest occur. His physician would be contacted, emergency services would be notified, and family would be notified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regent Care Center of El Paso	10880 Edgemere Blvd El Paso, TX 79935

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0678

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Record review of Resident #1's physician's orders dated [DATE] revealed no orders concerning his code status.

Record review of Resident #1's Advance Directives information in his electronic record accessed [DATE] revealed his CPR (Resuscitation) Status was Attempt CPR.

Record review of Resident #1's progress note dated [DATE] at 10:53 AM by RN A documented the following Resident found unresponsive by this nurse, initially attempted vitals but was unsuccessful, CPR initiated immediately, code cart brought to room, AED in place with commands initiated, 911 called, CPR continued till EMS arrived and took over. DON, Administrator, and MD notified. Family called and updated. All questions and concerns addressed.

Record review of the fire department's Hospital Care Report for Resident #1 dated [DATE] beginning at 7:55:12 AM revealed that paramedics were dispatched to the facility at 7:56 AM and arrived at the resident's bedside at 8:07 AM. The resident was pale and cold, pulseless and apneic (not breathing) and facility staff were performing compressions. Facility staff reported to the paramedics they noticed the resident was not breathing at around 7:20 AM and had called 911 around 7:55 AM. The paramedics took over compressions, established IV (needle in a vein) access, placed oxygen on the resident and administered epinephrine (adrenaline) and normal saline. The patient (Resident #1) was found in asystole (without a heartbeat) and remained in the same cardiac rhythm. The paramedics contacted physician (unidentified) who gave permission to discontinue ALS (Advance Life Support) interventions. CPR was discontinued on [DATE] at 8:17 AM. The paramedics advised the nurse at the facility of the doctor's orders, and the paramedics left. The resident was not transported from the facility.

Record review of the facility's self-report Intake Investigation Worksheet dated [DATE] revealed an allegation of neglect because RN A found Resident #1 unresponsive on [DATE] at 7:38 AM but did not initiate CPR until 16 minutes later at 7:55 AM.

In an interview on [DATE] at 8:31 AM, the ADON revealed she received a telephone call at 7:40 AM on [DATE] from the DON that RN A had texted the DON at 7:38 AM that Resident #1 had expired. The DON asked the ADON to go to the facility to initiate CPR and call 911. The ADON stated she arrived at the facility at 7:54 AM and found RN A at the nurse's station at the front of the building. Per the ADON she asked RN A who was with Resident #1 and RN A said No one. The ADON stated she then ran to Resident #1's room with RN A and when she arrived the crash cart was in the resident's room but there were no staff members there. The ADON said she called 911 at 7:55 AM while RN A initiated CPR assisted by LVN D, and CNAs C and E who had arrived at the room by then. Per the ADON, CNA C had gone into Resident #1's room to get him up for breakfast, found him unresponsive, and notified RN A. The ADON stated she asked RN A why CPR was not initiated, and RN A said that he was already cold and grey, and that she (RN A) did not know what to do, that this type of situation was handled differently in the hospital where she had worked before. [RN A date of hire [DATE]]. The ADON stated that RN A had not alerted other nurses in the facility about Resident #1's condition. She said that an investigation was done, with RN A being suspended and later terminated in response to the investigation.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regent Care Center of El Paso	10880 Edgemere Blvd El Paso, TX 79935

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 12:39 PM, the DON revealed that when CNA C told RN A that Resident #1 was unresponsive and the RN found the resident unresponsive, the RN should have started the code. She said the Code Blue procedure involved the nurse getting help from other staff in announcing Code Blue on the intercom, taking the crash cart and AED to the resident's room, and calling 911 while responding nurses and other responding staff would place a back board under the resident, start chest compressions, place and use the ambu-bag (bag used to help a patient's breathing), place the AED pads on the patient's chest and follow instructions from the AED machine. The DON said that that these compressions, use of the ambu-bag and following instructions from the AED should continue until paramedics arrived to take over the situation. She said that RN A was suspended pending investigation of the incident, and later was terminated. In an interview on [DATE] at 4:59 PM the DON revealed that the facility had not done any training about how to respond to this type of emergency [an unresponsive patient who is full-code], because nothing like this had happened before. She stated that nurses learned about CPR in outside classes when they got their CPR cards renewed. Telephone attempts to reach RN A were made on [DATE] at 9:34 AM, and on [DATE] at 8:15 AM, 9:21 AM, and 11:24 AM with no response although requests for a return call were left in her digital mailbox. Record review of RN A's personnel file revealed she was hired on [DATE]. She initialed a New Hire Orientation Acknowledgement that included location and information about the AED on [DATE]. In an interview on [DATE] at 8:31 AM, LVN D said she became aware of the incident involving Resident #1 before breakfast on [DATE] when RN A came to her asking what the procedure was when a resident was found with no vital signs. LVN D said RN A was not sure if Resident #1 had a DNR order or had a full code status. LVN D said she went to the nurse's station and found a green sheet of paper in his file [denotes full code status] and then looked in his electronic chart which also showed he had a full code status. LVN D said when she discovered Resident #1 had a full-code status she ran to get the crash cart and AED, took them to Resident #1's room. LVN D stated when she arrived at Resident #1's room the room was empty. LVN D said she and RN A arrived at the resident's room together and put the board under his back, opened the AED and placed patches on the resident, started CPR. LVN D said the AED did not shock him. At some point the ADON arrived and was using the ambu-bag. LVN D was not able to state when the ADON arrived. In an interview on [DATE] at 8:56 CNA E revealed that the morning of [DATE] around 7:25 AM, she was walking down the 400 hall when CNA C came out of Resident #1's room and said he was not moving. CNA E said she looked at Resident #1 who looked grey and was cold to the touch. CNA E said she and CNA C stepped outside the room where RN A had her cart and told the RN that she needed to go into the room because Resident #1 was gone. CNA E said the RN went into Resident #1's room, touched the resident, and pulled the sheet over his head. CNA E said she told the RN Don't do that and the RN pulled the sheet back down. CNA E said the RN then left the room and once outside asked the CNA (CNA E) what the procedure was. CNA E said she did not respond to the RN's question but instead told CNA C what the CNAs did when told by a nurse that a resident had died (wash the body, change the linens, use a towel to close the mouth). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Regent Care Center of El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE 10880 Edgemere Blvd El Paso, TX 79935	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on [DATE] at 10:52 AM, CNA C revealed she arrived for work on [DATE] around 6:00 AM and began her work. After readying several residents for breakfast, she asked RN A what she needed to for Resident #1. RN A told her to get him up for breakfast, but when CNA C entered Resident #1's room to begin getting him ready, she saw that the resident's face and hands were discolored, and his mouth was wide open. The CNA said she looked at the resident's chest and did not see him breathing. CNA C said she walked out of room and told RN A something was wrong with Resident #1, that he was not breathing and was not ok. CNA C said she went with RN A into Resident #1's room and saw the RN check the resident's pulse and breathing. The CNA followed the RN out of the resident's room where RN A was heard asking CNA E what the procedure was because it was different in different states. CNA C stated she was later going to the dining room to help with breakfast when she saw the ADON, RN A and LVN D go to Resident #1's room with the crash cart. She followed them to the resident's room where she observed the three nurses place the back board, start chest compressions, attach the AED to the resident, and begin use of the ambu-bag. In an interview on [DATE] at 4:22 PM, LVN F revealed that on [DATE] before breakfast (was not able to give specific time) she heard unidentified staff members saying that Resident #1 had expired. LVN F said she was surprised because no one had called a Code Blue. LVN F said she went to Resident #1's room where LVN D, RN A and CNA C were beginning to place the back board under the resident and to start compressions. In an interview and record review on [DATE] at 3:45 PM with the Administrator and the DON, the Administrator revealed that nurses are given a one-day orientation to the facility policies, and three days of orientation on the floor with experienced nurses regarding protocol to make sure nurses are ready to work the floor. The DON then signs the paperwork regarding orientation. The Administrator stated that that the orientation with experienced nurses on the floor included the AED, the Crash Cart and how to determine code status. When asked when the crash cart and determining code status were not included on the orientation check list, the Administrator stated that the AED is on the orientation check list, and the Crash Cart was in the same area as the AED. Record review of the facility's policy Emergency Procedure - Cardiopulmonary Resuscitation dated , d+[DATE] revealed that if an individual is found unresponsive and not breathing normally a licensed staff member who is certified in CPR/BLS (cardiopulmonary resuscitation/Basic life support) shall initiate CPR unless it is know that a DNR order that specifically prohibits CPR and/or external defibrillation exists for the individual. If the resident's DNR status is unclear, CPR will be initiated until it is determined that there is a DNR order or a physician's order to not administer CPR. Record review of the facility's policy Abuse and Neglect - Clinical Protocol dated [DATE] revealed that the definition of neglect was the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The physician and staff will help identify risk factors for abuse within the facility such as those related to staffing such as poor preparation, training, and lack of knowledge or skills that might affect how the residents are being cared for. Staff and management will help identify situations that might constitute or could be construed as neglect such as inattention to advance directives. This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 10:25 AM. The Administrator was notified. The Administrator was provided with the IJ template on [DATE] at 10:25 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Regent Care Center of El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE 10880 Edgemere Blvd El Paso, TX 79935	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Plan of Removal was accepted on [DATE] at 12:12 PM: [DATE] Employee was interview and statement taken. This was completed by [DON name] RN, DON and [ADON name] LVN, ADON on [DATE]. Met with Administrator and decision was made to suspend employee same day on [DATE]. This was completed by [DON name] RN, DON and [Administrator name], Administrator on [DATE]. Investigation begin by interviewing staff members and taking written statements. This was completed by [DON name] RN, DON on [DATE]. [DATE] Full code and DNR audit were completed to ensure, physician order, code status icon and correct colored paper (green or red) is in chart for all residents. This was completed by [LVN B Name] LVN, Medical records on [DATE]. Continued to take statements from staff members. This was completed by [DON name] RN, DON on [DATE]. Audit CPR certification for nurses completed This was completed by [DON name] RN, DON on [DATE]. CPR certification class was scheduled for Thursday [DATE] at 1:30pm. This was completed by [ADON name] LVN, ADON on [DATE]. In-service on where to find a residents' code status provided to staff. This was completed by [DON name] RN, DON on [DATE]. [DATE] In-services on "Emergency response procedure, calling a code" provided to staff. This was completed by [DON name] RN, DON and [Corporate Staff Name] RN, EDCS on [DATE]. Continue investigation by taking staff statements. This was completed by [DON name] RN, DON and [Corporate Staff Name] RN, EDCS on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER: Regent Care Center of El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE: 10880 Edgemere Blvd El Paso, TX 79935	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] In-services continued on ''Emergency response procedure, calling a code'' This was completed by [DON name] RN, DON and [Corporate Staff Name] RN, EDCS on [DATE]. Continue investigation by taking staff statements. This was completed by [DON name] RN, DON and [Corporate Staff Name] RN, EDCS on [DATE]. [DATE] Continue investigation by taking staff statements. This was completed by [DON name] RN, DON and [Corporate Staff Name] RN, EDCS on [DATE]. [DATE] In-serviced nurses about what to do when a patient is full code or DNR and found with no signs of life. This was completed by [DON name] RN, DON on [DATE]. Facilities Plan to ensure compliance quickly [DATE] Staff in-service on ''Abuse and neglect'' and ''Emergency response procedure, calling a code: verification of code status, instructing staff to activate emergency response system code, call 911, and initiate basic life support''. Staff members will not assume any job responsibilities until training has been received by DON/designee This was completed by [DON name] RN/DON on [DATE]. This will be monitor by DON/designee by conducting 5 random interviews x1 week with staff, record responses and document in regards to knowledge about abuse and neglect and how to reach/do in a code blue situation. DON/designee will report monthly to QAPI [DATE] and ongoing CPR certification class and emergency mock drill training provided on [DATE] at 1:30pm. Will be completed by [Business owner's name] (Owner of [Business name and location]). This will be monitor by DON/designee by conducting 5 random interviews x1 week with staff, record responses and document in regards how to react/do in a code blue situation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Regent Care Center of El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE 10880 Edgemere Blvd El Paso, TX 79935	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	DON/designee will report monthly to QAPI Ongoing Emergency mock drills training quarterly. Will be completed by [Business owner's name] (Owner of [Business name and location]). This will be monitor by DON/designee by conducting 5 random interviews x1 week with staff, record responses and document in regards how to react/do in a code blue situation. DON/designee will report monthly to QAPI Plan of Removal was verified a follows: - Confirmed through interview and record review (DON, [DATE] 4:59 PM; HR Manager [DATE], 9:43 AM) that alleged perpetrator was interviewed, suspended and terminated. - Through interview with 3 LVNs from 6 AM to 6 PM shift and two LVNs from 6 PM to 6 AM shift confirmed understanding of training regarding response to resident without signs of life (LVN F, [DATE] 4:22 PM; LVNs - [DATE] 9:04AM, [DATE] 2:22 PM, 5:08 PM, 5:16 PM.) - Confirmed through interview (Medical Records Director, [DATE] at 3:11 PM) that an audit was performed on all resident records to ensure accuracy of resident code status; confirmed through record review of residents physical and electronic charts ([DATE] at 4:04 PM) the accuracy of resident code status for 12 sample residents (Census of 75). - Confirmed through record review (audit listing with nurse's names and CPR expiration dates) and interview (DON [DATE], 5:05 PM) that nurses' CPR training status was audited, and that the facility has taken action to train one nurse whose CPR training was expired. - Confirmed through observation (Group trainings observed [DATE], at 2:07 PM, 2:50 PM, 3:58 PM), interview (DON [DATE] at 5:05 PM) and documentation (Inservice sign-ins dated [DATE], [DATE], [DATE], [DATE]) that trainings regarding calling a code and regarding determining a resident's code status as identified in the plan of removal were provided. - Confirmed through interview (Administrator [DATE] 3:30 PM) and record review (Service Agreement dated [DATE]) that the facility entered into a service agreement with a provider of BLS and First aid/CPR/AED courses. - Confirmed through interview and record review that ANE training is provided to employees and through interviews with 13 staff (RN (DON [DATE] 5:05 PM; RN [DATE] 2:03 PM), LVN (LVN F, [DATE] 4:22 PM; LVNs [DATE], 5:08 PM, 5:16 PM, CNAs - [DATE] at 10:52, [DATE], 1:52 PM, 1:59 PM, 2:33 PM, 2:57 PM, 3:07 PM, 3:30 PM; 3:40 PM), Restorative Aide ([DATE], 2:11 PM), Activities Director ([DATE], 2:16 PM) understanding of the concept of neglect. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regent Care Center of El Paso	10880 Edgemere Blvd El Paso, TX 79935

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Confirmed through interview that employees (DON [DATE] 5:05 PM) who have not completed Emergency response procedure, calling a code: verification of code status, instructing staff to activate emergency response system code, call 911, and initiate basic life support training will not assume job responsibilities until training has been done. The Administrator was informed the Immediate Jeopardy was removed on [DATE] at 6:55 PM. The facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm, and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.